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This guide for the development of training programs to prepare neighborhood residents to function as staff members in Comprehensive Health Services Projects is organized into an introduction and nine other sections. "A Special Training Program" discusses jobs and careers, learning style, practice, and basic skills. "Planning for the Training Program" discusses the development of job categories and assessment of community resources. "Recruitment and Selection" suggests approaches, emphasizes the importance of the recruitment of men, and considers the relevance of previous educational achievement. "Training Program" covers the phases of training: orientation, core training, skill training, on-the-job training, remediation, and counseling. "Schedules" discusses sequencing and integrating program phases and determining program length. "Training Supplements" discusses curriculum development and provisions for feedback. "Structure of the Training Program" discusses composition of the training staff and other resources for training such as other federal programs and colleges and universities. "Orientation of Professional Staff" treats content and approaches for inservice education. "Upward Mobility" discusses developing rungs in the career ladder and securing advanced training outside the center. (JK)

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an introductory guide to training neighborhood residents in comprehensive health services programs

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I. Introduction

This manual has been prepared primarily for the Project and Training Directors of Comprehensive Neighborhood Health Services Projects. The *Guidelines* for this program state that:

> "As an integral part of the work plan, neighborhood residents must be trained and employed as staff members of the project. Maximum employment opportunities, including opportunities for career advancement, shall be provided to members of the poverty groups being served . . . New ways should be sought to develop, train, and utilize a health team that is innovative in both structure and function. The concept of supporting staff should go beyond the traditional roles and might include physicians assistants [and] family health workers, . . . and others who contribute a firsthand understanding of the neighborhood and its people. The program should demonstrate new roles in the health-related professions and test realignments of the orthodox relationships between primary and supporting personnel."

In the development of Neighborhood Health Centers and other Comprehensive Health Services Projects, the Office of Economic Opportunity is interested in stimulating and assisting innovative and experimental efforts to involve poor persons more effectively in the provision of ambulatory care services. These efforts aim to make better use of the talents and knowledge of both residents of low-income areas and health professionals. From these pioneering undertakings will come learning to enrich both the lives of individuals and the methods of health care delivery.

II. A special training program

Experience in a number of Neighborhood Health Centers, in the sixteen Home Health Aide demonstration projects supported by the Office of Economic Opportunity, and in a number of other training projects designed to place poor neighborhood residents in jobs in human service agencies, has demonstrated the need to design special training programs for community residents to be employed in Comprehensive Health Service Projects.

1. Jobs and Careers

The primary focus of your training program must be specific jobs. You must first determine exactly what the jobs in your Health Center will be, based on the functions required. Then you can fashion a program to train people for those jobs. At the same time, plans should be developed for career advancement. Great care must be taken to avoid establishing dead end jobs for the neighborhood residents.*

All too often, poor people have been excluded from meaningful work in the field of health. They have been relegated to jobs of low status that offer little satisfaction or chance for advancement. The OEO health programs as well as the manpower shortage in health services have stimulated pilot projects that are seeking new ways to train poor people in health-related jobs, new jobs for them to fill, and new patterns of career development.

Comprehensive Health Services Projects can make a unique contribution by training the disadvantaged to fill jobs previously closed to them, or jobs that have never existed before. In the Neighborhood Health Centers, many new jobs have been created to take advantage of the special skills and experiences of neighborhood residents by "restructuring" the traditional roles of the physician, nurse and social worker. The restructuring involves examining the functions of these professionals and deciding which of the tasks they perform can be handled as well or better by persons with less formal training.

Experience has shown that poor persons can be trained to provide such functions as individual and family counseling, to follow up on medical instructions, to take temperatures and blood pressures, to take histories, to do case finding, to provide personal care, and myriad other tasks. These tasks draw upon their special ability to relate to other neighborhood residents.

*See "A Strategy for New Careers Development," by J. D. Grant, in *New Careers for the Poor,* by Pearl and Reissman, Free Press, N.Y., 1965, pp. 209-238. Also, *Position Descriptions for New Careers,* National Institute for New Careers, University Research Corporation, Washington, D.C., 1968.

Further, the neighborhood workers explain the Center to the community; as a result, the Center's services may be sought more readily. Also, they help explain the community to the center's health professionals; thus, the physicians and other staff may be more effective.

Every Neighborhood Health Center employs some neighborhood residents in subprofessional roles. Some Centers have more than one hundred community residents on their payrolls. The job most frequently filled by residents is the Family Health Worker or Advisor, a new role that has emerged in the early development of Neighborhood Health Centers, combining skills in nursing, outreach, case-finding and referral. Other subprofessional jobs in the Centers are Nurses Aides, Laboratory Aides, Dental Aids, Pharmacy Aides, X-Ray Aides, Child Care Aides, and a variety of secretarial and administrative positions.

2. Learning Style

The experience of poor persons with traditional classroom techniques has been largely negative. Your training program must be designed to avoid repeating such bad experiences.

Instead of lengthy lectures to a passive group, the trainer must actively involve all the trainees in creating the learning experience. Trainees learn best by seeing and doing, by repetition and practice.

Field trips to other human service agencies, group discussions, role playing—all these techniques keep the trainees involved as active participants. Role playing is also effective in providing trainees with opportunities to try out new roles and relationships. Audio-visual devices, including films, followed by discussions, are helpful with a group that does not easily gather information from the written word.

The training schedule, and the various techniques used, must be flexible and varied. A stultifying routine will inevitably produce dropouts.

3. Practice

Because of the trainees' distrust and impatience with protracted classroom experience, and because they learn best by doing, they must be given every opportunity to put into immediate practice the skills and concepts they learn in class. Further, the practice sessions must be structured to provide the trainees with successful experiences; success in their lives has been all too rare.

The best way to structure practice sessions for trainees is to phase them into actual jobs in the Health Center, under appropriate supervision, after a brief period of orientation and classroom training.

The classroom training continues throughout the training period; it should be designed to supplement and build on the learning that takes place on the job.

4. Basic Skills

The need to consolidate or increase the basic communications skills—reading, writing and speaking—is essential to the trainees' success in the training program and on the job. Facility in the basic skills is needed to promote learning and to underpin health skills and concepts. For example, a trainee can learn that if the mercury goes above the red line on a thermometer, the patient has a fever; but an understanding of decimals and of the Farenheit scale will make temperature readings more meaningful.

Reading and writing skills are also essential to function effectively on the job. The worker will have to write reports, read and interpret instructions in medication, insurance, welfare and the like to patients and their families, and effectively communicate to the neighborhood the services of the Center and the concepts of good health care.

Basic education and learning must continue if job responsibilities and pay are to increase. Beyond entry-level jobs, credentials such as the high school equivalency become important to upward mobility, and therefore should be initiated during entry-level training.

III. Planning for the training program

In order to implement the concepts outlined so far, the Training Director in a Neighborhood Health Center must work closely with the rest of the Center staff in planning the training program.

With the senior staff he must decide on the categories of jobs to be trained for. Generally, the first cycle of trainees for a new Center should contain as few categories of specialized workers as possible. Initial training should cover the basic needs of the Center (for example, Family Health Worker, Nurses Aide, and Medical Records Aide).

The first few months a Center is open are a time of rapid learning for all. These burdens should not be increased by training neighborhood people for positions that cannot be utilized right away. For example, the jobs of Pharmacy Aide and X-Ray Aide might be scheduled for later training activities.

Concurrent with discussions about numbers and categories of trainees, you will have to work with the staff in developing careful job descriptions for each position. At that point you should also begin to develop the curriculum you will use (see Section VII p. 9).

Before you begin recruitment and training, you should make a careful assessment of the training resources in your community and among the Center staff that could contribute to the success of your training program. For a more detailed discussion of tapping community training resources, see Section VIII pp. 10-11.

If your training program is a good one, you will have very few dropouts. Manpower programs that do not have guaranteed jobs as a payoff and aren't responsive to the special needs of the trainees tend to lose great numbers of trainees along the way. Your program, which includes the goal of identified jobs, should be a dramatic contrast.

IV. Recruitment and selection

Recruitment and selection are frequently responsibilities in which the Neighborhood Health Council participates, with the Training Director serving as an advisor.

1. Recruitment

The Project and Training Directors should meet with the Council to explain the goals of training and employment of neighborhood residents and to receive their ideas and assistance. Together they will set requirements and priorities for recruitment, since there are likely to be many more candidates than available positions. Usually priority is given to trainees who are poor and are residents of the Center's service area. Some Centers give first priority to unemployed heads of households. Some look particularly for older adults, some aim to recruit school dropouts under 25.

Referrals may be requested from the local Community Action Agency, welfare and other community service centers, senior citizens' clubs, and the local employment service. Sometimes the Council may issue posters or arrange for newspaper notices advertising the opportunities. Word of mouth communication is often extremely effective, especially in the recruitment of men.

2. Selection

Selection methods vary. No single method has proven perfect. Most projects rely on individual interviews. Some have been very pleased with small group interviews, in which several applicants discuss their views about community health problems and other topics with members of the Health Council and the Training Director. This kind of interview has the advantage of allowing the applicants to interact informally with their neighbors and gives the interviewers important information about the ability of the candidates to relate to their peers—information not provided by speaking to one applicant at a time. Also, the group interview is usually much less stressful for applicants than facing one or more professionals alone.

The value of time-consuming vocational tests in the selection process has not been demonstrated. Such tests usually create a great deal of discomfort and this lessens their value in helping selection. They also tend to recreate situations in which poor persons have experienced failure before.

A physical examination should be arranged in order to detect major problems or diseases that need care and correction, and that would interfere with successful employment.

3. Recruitment of Men

It is important to make every effort to attract men to your training program, in order to provide employment and advancement opportunities to those who are often overlooked. However, there have been serious difficulties in the recruitment of men to health programs, due largely to these factors: (1) most health occupations are regarded as "women's work;" (2) salaries are usually low and insufficient to support a family; and (3) there has been little chance for advancement.

Various efforts have been made to counteract these difficulties, with still limited success. For example, some projects have stressed certain job areas most acceptable to men, such as X-ray, laboratory and administration, or jobs that don't need elaborate skill training, such as transportation and security. Some have offered higher salaries to heads of households. The presence of advancement possibilities in the Health Center is perhaps the most important factor in your ability to recruit and hold men in your training program.

4. Importance of Educational Achievement

Most entry-level health positions do not require more than an eighth-grade ability to read and write. Many projects have found that it is misleading to use arbitrary grade school levels as yardsticks in assessing an applicant's potential for success. Far more important are attitude, interest, physical health, and emotional stability. In fact, there is a great deal of evidence that the most valid basis of successful selection is assessment of actual job performance, and not what the new trainees bring to the training program by way of education or measurable aptitude.

V. Training program

1. Orientation

The first few days of the training program are generally given over to a thorough explanation of the goals and operation of the training program and the Health Center. The trainees should learn what the personnel policies of the Center are: what are the hours of work, what they are to be paid, what days are holidays, what provisions are made for sick leave and annual leave, and so on, as well as any penalties imposed for infractions of the rules. The workings of the Center and the staff relationships should be discussed, and the staff introduced. Orientation is usually conducted by the Training Director.

Especially during the early classroom phases of training, remember to allow ten or fifteen minute coffee breaks in the morning and afternoons, to avoid too-long stretches of time in the classroom.

2. Core Training

"Core training" is that broad training offered to all neighborhood residents who will be working in the Center as subprofessionals. The core curriculum usually contains the following general topics, among others:

Human Growth and Development. This covers basic aspects of physical and psychological growth and development, family dynamics, patterns of childhood and adolescent development, and other elements of psychology. The trainees will learn how people react to stress, and how to seek and identify alternative choices.

General Health Information. This information will supplement the human growth and development subject matter. Many trainees will not have had or will have forgotten basic high school health and hygiene courses. A course in first aid is often offered all trainees.

The Community. A study of their own community and its service systems—health, welfare, education, law enforcement—will help the trainees learn how to "negotiate" those systems and get the most assistance from the community's political, economic and social resources. A study of the Medicare and Medicaid programs might fit here.

The Culture of Poverty. This aspect can help trainees gain a broader perspective on poverty's causes and its results, and the role of the poor in combatting them.

Current Events. Trainees should be helped to see the interrelatedness of world and national and local events to their neighborhood and personal situations. Newspaper clippings can stimulate thought and discussion of situations in the Health Center.

General Job Skills. Since many trainees have never held jobs before in a human service agency, they will need practice in such skills as: making contact with the public; speaking clearly on the telephone and taking accurate messages; making accurate observations and writing them down clearly; keeping simple records; and the like.

Orientation to Health Careers and Other Human Services. This topic will help the trainees to gain knowledge about health care delivery systems, to work effectively with professionals, and to learn how health services are related to other human services.

The core training is generally conducted in small groups, no larger than 10–12 persons. This offers a number of advantages:

> "First, the group provides a reference point for change in the lives of the trainees. Since trainees do not possess the skills or life styles that permit ready entrance into human service occupations, they are placed in the uncomfortable position of having to renounce previous patterns of behavior as dysfunctional. Caught in the pull between familiar life styles and the new life styles they must acquire, they need a source of strength and support. The support of their peers in the small groups enables them to better resist the pull of old friends and familiar ways.
>
> "Small groups inevitably provide a forum for reality testing—an opportunity to examine one's own reponses to others, to examine the reactions of others to one's own behavior, and to re-examine values and attitudes. It is difficult in a group, for example, to avoid recognizing how one defends one's self against others, brings trouble to one's self, or deals irrationally with people. The opportunity to judge one's self in relation to peers often precludes the need for confrontation with the group leader or person of authority. Individuals in small groups also tend to keep one another in check and police their own behavior.
>
> "The group setting serves to increase and sustain the motivation of the trainees. The successful trainee who has discovered new abilities provides encouragement and impetus for others. Trainees often comment, 'If he can do it, so can I.' Seeing a peer succeed encourages the others to continue, to 'stick it out,' to 'make it.' It provides enormous psychological support and helps trainees become more involved in the program. Seeing others in similar situations with similar difficulties makes the training process

less humiliating than it might be on an individual basis or in a large group.

"Finally, group pressure facilitates the adoption of the new set of values and attitudes compatible with the wider society—attitudes crucial to success in human service work. This group pressure is much more meaningful than pressure by authority or 'the man;' it also has the effect of reducing the tendency to slide by or to be 'slick.' The peer group provides the pressure to cooperate, regardless of one's desire to do otherwise."*

The core training, generally conducted by the Training Director or a Training Specialist, continues throughout the training period, initially for several hours a day and gradually phasing out to perhaps several hours a week by the end of the training program.

Successful core training gives the trainees specific pieces of information they can relate to their life situations and their new jobs. It also fosters group identity. This, in turn, supports and encourages them in the development of greater personal maturity and effectiveness.

The small core training group also in many ways fulfills an effective group counseling function, by placing counseling in the context of work and job experience, making it relevant to the problems the trainees face in their work and social situations. (See p. 8.)

3. Skill Training

In skill training, the trainee learns specific skills he will need on his job that are not common to all job categories in the Health Center: how to work with community agencies, how to set up a tray for a doctor, take a patient's temperature, conduct a preregistration interview, take a dental X-ray, and so on.

Sometimes the skill sessions will be conducted by the department heads or other staff of the Center. Sometimes outside experts in the field will be called in to conduct the sessions. The Red Cross, for example, gives first aid training, as do local fire departments.

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*Avis Y. Pointer, M.S.W. and Jacob R. Fishman, M.D., *New Careers: Entry-Level Training for the Human Service Aide,* National Institute for New Careers, University Research Corp., Washington, D.C., 1968, p. 16. See also J. R. Fishman et al., *Training for New Careers,* President's Committee on Juvenile Delinquency and Youth Crime, 1965, pp. 18-28.

4. On-the-Job Training (OJT)

This component of the training program gives the trainee an opportunity to put into practice the skills he has been taught in the skill training component. He needs this experience as soon as he has been taught the skills, and he must have the opportunity for constant practice, with appropriate supervision.

Perhaps more importantly, OJT also provides the trainee the opportunity to learn skills through doing, in a process which is much more vivid and effective than the classroom teaching can be for him. Particularly in health occupations, many skills can be first and most effectively taught in the OJT setting.

The OJT component of the training program must be recognized by the supervisors as an integral part of the program and of the objectives of the Neighborhood Health Center. The trainees will be performing useful tasks on the job, but they still require a great deal of supervision, because the tasks they are performing are new to them and because the trainees are likely to be particularly anxious during their initial assignments. The difficulties of this experience can be minimized by keeping trainees informed of exactly what is expected on the job, by close supervision, and by increasing the numbers and complexity of tasks gradually to keep up with what the trainees are learning in the classroom.

This component will generally be conducted by those who will supervise the aides after they have become full-fledged employees of the Neighborhood Health Center. OJT should begin right after the orientation period, for a few hours a week, and gradually increase as the trainees master more skills.

In cases where the Health Center has not opened for services, on-the-job training will have to be "farmed out" to appropriate institutions in your community. The back-up hospital for the Health Center should be able to accommodate the Nurses Aide trainees; perhaps they could also find places for the Medical Records trainees. The Tuberculosis Association in one city provided OJT experience in health education and outreach to a group of Family Health Workers. Hospitals or local day-care facilities, including Head Start, may help you with the child care trainees. Local private dentists have trained Dental Aide trainees in several communities.

Because the OJT component is such an important part of the training program, the relationship between the trainees and their supervisors is critically important. A great deal of attention should be given to preparing and working with the OJT supervisors (see Section IX).

5. Basic Skills and Remediation

Remediation based on the trainees' individual needs should be a constant thread throughout the basic training period—and beyond, where possible and necessary.

In order to determine what skills and sharpening are needed, some testing is in order. Some trainees will need no special help in the basic skills; others may be rather high in one area and low in others. Shape your program to take differing needs into account. Much programmed material is available that lets the student begin where he needs help—not necessarily at the beginning—and progress at his own rate.

You will probably want to engage the part-time services of specialists in remediation and adult basic education, perhaps one in reading and writing skills and one in mathematics.

Several hours each week, and initially, some time every day, should be set aside for this important aspect of your training program.

The trainees themselves are likely to realize very quickly the importance of good communications skills in their jobs and in their comprehension and acceptance of the rest of the training program itself. The OJT supervisor may want the trainees to fill out registration forms for the patients, to help with answering the telephone and making appointments, or to type a technical letter for a physician. None of these tasks can be done well without a solid grounding in the basic skills. The remediation teachers and the OJT supervisors can reinforce each other's work if they each keep abreast of the other's requirements. The various record forms used in the Center can be utilized as practice material in the classroom, both in remediation and skill classes.

The possession of the high school equivalency, or the GED, should not be viewed as essential to successful employment at the entry level. However, if the employee is to move up and perform jobs with higher pay and more responsibility, either within the Health Center or in other institutions, the GED will assume great importance. Employers and especially licensing and credential committees rely on it. Thus, while recognizing that there are many artificial exclusionary requirements for health jobs which need revision and flexibility, we must not hold back those who wish to move ahead by denying them a chance to acquire the GED. Specific preparation for the GED should be made available to the trainees that wish it.

One project has made arrangements with the school system for GED preparation; a teacher comes to the training facility two evenings a week. Others arrange classes in the schools.

Some trainees will enter the program already possessing a high school diploma or equivalency. It is desirable to arrange study for them at the community college level to increase their skills and provide a foundation for career advancement (see Section X).

6. Counseling

The trainees will normally have a number of problems arising from or brought to their training and job situations. The most effective kind of counseling for the neighborhood trainees has been shown to be group counseling. Thus the core training group itself can be an extremely valuable counseling tool. If the emphasis in that group is on work and social living and coping skills—problem-solving—the problems dealt with are more realistic to the trainees, and more manageable, and the value of behaviorial change is more apparent to them. (See the previous discussion on the strengths of the group setting, pp. 6 and 7.)

The Training Specialists can meet individually with trainees if they are requested to do so, to follow up on issues that might have received incomplete treatment in the group.

A word of caution should be introduced. The group counseling approach we are discussing here should not be thought of, or tried out, as formal group therapy. Even so, the Training Specialists who will lead the core training groups should be aware that their role is complex and demanding.

> "In essence, the leader must be a strong authority figure who delegates much of his power for decision-making to the group, without surrendering his role as teacher, counsellor, stimulator of inquiry, source of information, and reality-tester. . . . . He is not there as group 'therapist'—a role which, for the contemporary professional, is a great temptation. . . . . Moreover, the leader must find, support, and respect within each of the [trainees] those qualities *that make for effective functioning and personal competence.* . . . Finally, he must be able to tolerate the floundering, indecision and lack of closeness that often affect the group, indicating by his tolerance and lack of anxious intervention that in *this* group decisions can be made and problems can be solved."*

If the staff member who will lead the core training group is not by training or experience or temperament suited to serving as a group counselor, the counseling function of the core training would be better eliminated entirely.

Some trainees may present themselves with incapacitating problems of a psychiatric or psychological nature, which may interfere with their function in the training program or on the job. These deep-seated problems should most appropriately be handled by a mental health professional, and such services should be made available. In such situations, it is important

**Training for New Careers,* op. cit., p. 28.

to remember that one is dealing with a medical matter in which medical ethics and confidentiality apply. Care should be taken to avoid a paternalistic kind of relationship in which the trainer or supervisor takes on the role of therapist. Remember that the trainees may well have psychological and social behavior patterns that are quite different from those of the supervisors—but because they are different does not necessarily mean the trainees are in need of therapy. What really counts in this program is job performance.

Since this is a career development program, vocational and educational counseling should be seen as an integral part of this component. Relevant as subjects for discussion in the group and on an individual basis are such issues as career goals, high school equivalency, college or vocational schools, scholarships, course work, and so on.

VI. Schedules

Training schedules should be flexible and varied. All the elements of training described in the previous section, after orientation, should preferably take place concurrently. While this is not always possible, you should strive for it mightily.

All aspects of training should reinforce each other. To make them all work together to mutual advantage requires sensitive scheduling. Keep in mind, too, that as one aspect becomes mastered by the trainee, he should spend decreasing time on it.

After orientation, training days should be given over entirely to core training (with field trips), remediation, and perhaps a bit of skill training. As the weeks go by, you will phase in more skill training and introduce the trainees to their job stations, initially perhaps one or two hours a day. Toward the end of the training period, the trainee will be working on the job six or so hours a day, with time scheduled for remediation as needed.

How long should the training program last? While there is no hard and fast answer, two to four months is usually adequate for entry-level jobs. One project, in which the local New Careers Program was involved, had a six-month training period; the trainees were stationed at their jobs in the Health Center almost full time for the last several weeks of training, going back to the training facility for core training and remediation.

Try to keep the schedule flexible to allow for individual needs. The project referred to above recalled trainees from extended OJT in several instances when it became apparent to their supervisors that more help was needed in remediation or counseling; once the benefit of the intensive support was realized, the trainees returned to the longer periods of OJT.

VII. Training supplements

1. Curriculum Development

The training staff, with the close cooperation of other relevant Health Center staff and as many outside experts as they need, will plan and develop the curriculum for the training program. At least its broad outlines must be set during the initial planning phase, before recruitment of the trainees. You will need to develop the general outline of curriculum for the core training, as well as the specific material to be imparted in the skill training sessions. For the latter, the specific instructors should carry the main burden of curriculum development.

For the core training component, you should identify those who will lead the discussions, be they staff, representatives of other agencies or community groups, or whoever.

Once you have the curriculum set, remember it is expendable. As the training program progresses, keep alert to sections that seem to bore the trainees, or are too compressed. Make appropriate adjustments as soon as possible. If you should have successive training cycles, revise to incorporate what you have learned about the strong and weak points of your curriculum.

2. Feedback

In order to keep abreast of the effects of the training program, both on the trainees and on the delivery of services in the Health Center, it is extremely important to hold frequent scheduled meetings between the training staff (both core and skill trainers), the OJT supervisors, remediation teachers, and other staff. You will want to learn: (1) are the aides being trained in the classroom to do what they are asked to perform on the job? (2) are they expected to do on the job only those tasks they are being trained to perform? (3) do individual trainees perform well? Should one or another be freed up for more OJT? Is one having particular difficulty on the job because of a plateau he has reached in math remediation? Is another having problems with her supervisor that group discussion in the core training session, or perhaps individual counseling, might help her to cope with?

Only when all the staff that has contact with the trainees get together and compare notes with one another will the impact of the training program be known. Be sure this happens in time to make early adjustments in the program.

Meetings of the staff and trainers are also inservice training for the staff itself. They will become much more aware of and responsive to issues and problems of poverty and its effects, job development, professionals versus nonprofessionals, etc., as a result of their participation in regular feedback meetings. (See Section IX.)

VIII. Structure of the training program

1. Staff

The training program described in this guide can be adequately handled by a small training staff of the Neighborhood Health Center, supplemented by resources in skill training, remediation and mental therapy as necessary. If the core training group is ten or twelve persons, cycles of twelve or twenty-four trainees can be trained by a Training Director and one or two Training Specialists, math and reading remediation specialists (possibly on a part-time basis), and some support from mental health professionals (possibly from the Center staff). This plan assumes skill training will be carried by the Health Center staff or by other health professionals and nonprofessionals from other institutions (possibly as paid consultants).

Other people outside the health field should also be brought in to help conduct the core training (e.g., representatives of civic and civil rights groups, health and welfare agencies, attorneys, etc.).

You should not overlook the advantages of utilizing experienced aides in all components of the training program. Their active presence in the Health Center can mean to the new trainees that they, too, can "make it." Nonprofessionals might profitably help conduct some of the core and skill training sessions, and assist in the orientation course for the professional staff (see Section IX).

It is helpful for the Training Director to have as much freedom from day-to-day training duties as possible. He needs time for the continuous planning and coordination of all the components of the training program. He also should have the major responsibility for the orientation of the rest of the Health Center staff to the roles of the new workers and to the goals of the Health Center.

The Training Director for a Neighborhood Health Center should be a good planner and administrator, a compassionate educator, and a consummate dip-

lomat. He must deal sympathetically and creatively with the trainees, with his own training staff, with the health professionals of the Health Center and other agencies, with city officials and with other educational institutions.

The Training Specialists who will have the most direct contact with the trainees need not be health specialists. They should have good rapport with community residents and be able to work well with the health professionals who will be serving as skill trainers and OJT supervisors. Preferably they will have had some background in anti-poverty or manpower activities, and some training in group process. (See the discussion on the core training leaders, p. 9.)

2. Other Resources

There are likely to be quite a number of training and educational resources available in your community that your entry-level training can draw on. The way you use them will affect the staffing pattern of your training program. You should contact them early in your planning.*

a. Federal Programs

Prominent among the other resources are the federally-supported manpower programs such as those under the Manpower Development and Training Act (MDTA) and New Careers.

The New Careers program is especially important since it offers a broader scope of training than is possible if all training is done in the Center. The New Careers project is able to hire a large specialty staff; its supportive services are also generally beyond the budget limitations of a Neighborhood Health Center (e.g., day care facilities); and it deals with agencies and trainees in other human service areas, such as education and welfare. Also, all training expenses, including stipends, are at no cost to the Health Center project.

In order to qualify for the New Careers program, an agency must guarantee permanent employment and the possibility of a career ladder to a certain number of aides, who will also presumably get their OJT experience in the agency. This guarantee can be easily forthcoming from a Neighborhood Health Center.

The New Careers program can make it possible to limit your training staff to the Training Director. He would work very closely with the New Careers Training Program staff in the development of the training program to see that the particular needs of the Health Center are met. He would serve as a liaison between the OJT supervisors (members of the Health Center staff, in most cases) and the other trainers (members of the New Careers staff). The Training Director's role as planner and coordinator of advanced training for upward mobility (see Section X) will not be affected by the placement of much of the entry-level training program outside the Center, nor will his role in the orientation of the professional staff be diminished.

b. Affiliation with Colleges or Universities

Some projects have contracted the bulk of the entry-level training to a local community college or university. When a college expresses an interest in providing the training you need, there can be several advantages to making the necessary arrangements. The college may have experience and expertise either in training the disadvantaged, or in training for the particular skills your Center needs, or both. Even more important, there is the possibility—which you should press hard for—of the trainees' receiving college credit for the training or for some combination of training and experience, if the college can vouch for the worth and relevance of the training.

While the payoff to the trainee may not be immediate, it will be very important when he wishes to move up and take advanced training or to enroll in an Associate of Arts degree program at the same college. Successful completion of the college-based training program should smooth the way for entry into the college (see Section X).

The college-based training arrangement still requires a Training Director on the staff of the Health Center to coordinate what happens in both places. Depending on the resources of the college and the Center, skill training sessions might be done either by the college or by the Health Center staff, or by a combination. The on-the-job training component should take place in the Health Center, if it is open. If not, the Training Director and the college should work out suitable arrangements for OJT in other institutions.

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*See *Federal Programs Which May Support the Training of Neighborhood Residents in Neighborhood Health Centers,* CAP Health Services Office, 1968; *Guide to Funding New Careers Programs,* by R. J. Gould, New Careers Development Center, New York, 1968; *Inventory of Federally Supported Adult Education Projects,* Greenleigh Associates, New York, 1968.

IX. Orientation of professional staff

1. Orientation Course

A neglected area in the usual training program is the orientation of the professional staff, among and for whom the nonprofessionals will be working. The professionals need to understand how to utilize the nonprofessionals well, and to accept their abilities and skills as essential in implementing the goals of the Health Center. They need to understand how the new workers can help ensure high quality personal care. Some may need to be reassured that the nonprofessional workers will not be replacing them or usurping their proper functions.

It is often difficult to "train" highly-trained health professionals. Nevertheless, some sort of orientation, especially to the problems of the community and the life styles of the poor, is in order for all staff members. The Project Director might conduct some of the sessions himself, to indicate the importance with which he views the orientation program. Experienced aides and other nonprofessionals have also been very effective participants in such programs.

Subjects that should be covered would include information on the nonprofessional training program, the goals of the Neighborhood Health Center, the structure of the community and the culture of poverty, and the relationship of the Center to other halth resources. The team approach to delivery of health care, including the role on the team of the Family Health Worker and other nonprofessionals, should be thoroughly discussed. Center staff as well as persons from other agencies and community groups should be brought in to lead some of the discussions.

It should be clear that a complete orientation to the professional's new job in the Health Center cannot take place in just one session. Several meetings should probably be held, and they should take place as soon as possible after the professional joins the Center staff. As the full staff is seldom hired all at once, a number of cycles of orientation should be offered.

When on-the-job training of the neighborhood residents has been arranged at sites other than the Health Center, the supervisors of your trainees in those agencies should, if at all possible, receive appropriate orientation also.

2. Feedback Meetings of OJT Supervisors and Trainers

As was mentioned above, the regular meetings of OJT supervisors (both Center staff and off-site personnel) and other training staff serve as an excellent vehicle for ongoing inservice training. These meetings provide opportunities for professionals to discuss the theories and observe the practices of training and supervising nonprofessionals. Just as the Neighborhood Health Center is patient-oriented, so should these meetings be trainee-oriented.

> "There will be a tendency to focus on those factors which, in the mind of the 'professionals,' will make the trainee a better person or will make him into something he is not. This must be avoided. The focus must be on finding ways to increase the unique potential the trainees possess."*

An outcome of these ongoing discussions should be a greater sensitivity on the part of the professionals to the many traditional barriers porr people face in developing independent and self-supporting careers in the health field as well as in obtaining necessary health care services.

**Entry-Level Training for the Human Service Aide*, op. cit., p. 12.

X. Upward mobility

So far most of the remarks in this booklet have been directed to preparing neighborhood residents for entry-level jobs in Neighborhood Health Centers. We have been talking about just that amount of training needed to perform the tasks outlined in the basic job descriptions you have developed, keeping in mind that most of those job descriptions will not be particularly complex, nor will the educational achievement level of the trainees be as high as the high school diploma in many cases.

The health field unfortunately is studded with entry-level jobs that go no further, that are simply dead-end jobs. The traditional hospital nurse's aide is one example, and orderly is another.

Many Neighborhood Health Centers are finding that they have a number of skilled aides who are eager and ready to move up. To crack the system of dead-end jobs, it will be necessary to provide opportunities for advancement beyond the entry level in the Health Center itself, and to help make available

outside educational and training opportunities to enable employees to move onward and upward in other institutions.*

1. Advancement in the Health Center

One route to accommodate ambitious aides is upward mobility in the Health Center. This calls for the same kind of careful development of second- and third-level job descriptions as for entry-level jobs. The job descriptions should realistically reflect what aides can learn in a reasonably short inservice training program, to meet expanding needs of the Health Center.

New salary ranges will have to be developed for the new jobs, which must be consistent with salaries of other Center staff and comparable to equivalent jobs in other agencies.

You will have to decide whether or not the second level will require the high school equivalency (GED). If the answer is yes, make sure arrangements are made to prepare for the exam.

One project drew up a lengthy and ambitious job description for Family Health Worker I, and then projected the Licensed Practical Nurse for the second level. They came to realize this was not a realistic goal, and have (1) scaled back the number of tasks the entry-level Family Health Worker is to perform; (2) inserted a second-level Family Health Worker position which adds on specific tasks and responsibilities that the entry-level job does not require; the GED is to be acquired while holding this position; and (3) made the LPN position the third rung on the career ladder, after outside education at a degree-granting institution.

As you draw up job descriptions for the second level, remember that while the responsibilities must be increased, this does not necessarily mean the aide must become a supervisor. There are many ways of increasing job responsibilities and only a relatively few people in any agency can become supervisors.

Also keep in mind the possibilities of transferring second- and third-level workers to other institutions in your community. If Family Health Workers, or their equivalent, don't exist outside your Health Center, you should work to establish them.

When job descriptions and salary scales are developed, you must plan how the aide is to achieve the second level. The path must be made clear to all aides, and the procedures must be followed consistently, to develop faith that the advancement system is honest and that it works. Decisions that will have to be made include: how much experience must an aide have on the job before he is eligible for promotion? Will outside training or education courses be required? What will be the nature of the inservice training program?

The tasks of the second-level jobs should require somewhat less supervision than is needed at the entry level. The aides will increasingly need to handle abstractions and make judgments. Correspondingly, the training may depend more on the written word and less on demonstrations and learning by doing, than was possible or appropriate at the entry level.

You will have to make arrangements for the aides to take time away from the job to participate in the training program. Since supervisors should have helped you develop the second-level jobs and curriculum they should be willing to cooperate in the training program. The Center will need to develop a policy on the extent to which training can be given on "released" time, during regular working hours; other training may be scheduled at night or on weekends.

If you develop a second-level training program and job description for one type of worker in the Center, you must be prepared to do the same—or make equivalent arrangements—for other job categories.

2. Advanced Training Outside the Center

Some of the training for second-level jobs in the Center, and probably all the training and education for jobs beyond that level, will take place outside the Center.

In one category are courses in secretarial skills, medical transcription, accounting, general education, computer technology and the like.

In another category are more extended programs leading to certification or accreditation in such areas as nursing (aides in various Neighborhood Health Centers are enrolled in programs leading to the RN, AN and LPN). Particularly interesting are the pioneering Associate of Arts degree programs for the development of the Family Health Worker in social work. A number of universities and colleges, especially community colleges and the newly-developing schools of allied health professionals, have expressed an interest in working with Health Centers along these lines.*

The scheduling of such advanced education programs—and in fact all training and education that takes place outside the Center—represents a challenge to the Training Director's persuasiveness and ingenuity. In the first place he may need to convince the Project Director and the department heads of the

*See *Building Career Ladders in Health Occupations: Opportunities and Obstacles,* by Sumner Rosen, Ph.D., New Careers Development Center, New York, 1968.

*See "Junior Colleges and the New Careers Program," by S. S. Steinberg and E. O. Shatz, *Junior College Journal,* Feb. 1968. Available from University Research Corp.

importance of further training for the aides. Not only will the aides learn to hold more responsible positions and earn more money, but if the job description and training are adequate, the Health Center's program will benefit from the added skills of the aides.

The Training Director will have to juggle the training schedules of the aides away from the Center in such a way as to minimize disruption of services to the Center. Since the prime responsibility of the Comprehensive Neighborhood Health Services Project is health services to the poor, the training of aides must not inhibit those services. Policies on the amount of released time during the regular working hours and the amount of released time on salary will need to be established. One-fifth released time, or eight hours a week in advanced training, seems to provide a workable study-to-work ratio in many situations.

Some programs, investigating AN or RN programs for their nurse's aides, have found them demanding many months at a time away from the Helth Center. One Health Center handled this issue (and the major problem that the aides would have been ineligible to continue to receive their salary during the extended absence from their jobs) by arranging for a large part of the clinical (OJT) experience of the training (particularly in pediatrics) at the Health Center itself. This schedule allowed the aides to be on the job at least half the time during their LPN training, except for a period of a few weeks of classroom work. Another program convinced the State agency which certifies laboratory technicians to accept the GED in place of a diploma and to credit work in the Center, under proper supervision, as acceptable on-the-job training; at the end of a year, the aides take an exam which can qualify them as certified laboratory technicians.

The question of tuition payments often arises. Since OEO Comprehensive Health Services Project grant funds may not be used for tuition payments to other institutions for advanced training or education, other arrangements must be made. One project convinced a local business college to contribute six tuition scholarships for secretarial aides; the Health Center paid for special materials. Other good sources of tuition payments are local foundations or charitable organizations. Since the total amount of money required is not likely to be very high, in some cases the aides themselves can manage the low tuition cost, an act which can be important to their sense of achievement.

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